

ADA ACCOMMODATION REQUEST

Part B: Licensed Professional Disability Documentation

Student Name: _____ Student email: _____
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To the Diagnosing Professional: Please provide the following medical information. This will be considered when determining reasonable accommodations for the above-named student. Any supporting documentation must be attached to this form and must be **legible (preferably typed), signed, and dated on letterhead.**

Diagnosis/Disability Requiring Accommodation:

Presenting limitations resulting from the above diagnosis with attention to the educational environment:

Duration of Disability (If temporary disability, please note here):

Recommended accommodations or adaptive/assistive services based on the diagnosis:

Please provide signature or official stamp below:

Licensed Professional Printed Name

Title, Licenses, Credentials

Licensed Professional Signature

Date

Official Stamp: _____
Hospital/Clinic/Practice Group Name, Address and Telephone